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14. ABSTRACT

The main objective of the study was to test a motivational enhancement (ME) intervention to address barriers to engaging in mental health treatment for recently returned veterans of Operation Iraqi Freedom and Operation Enduring Freedom. The long term goal of the study was to increase veteran's participation in mental health treatment by using a Stages of Change model to reduce perceived stigma and barriers to treatment. The central hypothesis put forth was that veterans who receive motivational enhancement will demonstrate greater readiness to change and higher treatment program attendance than veterans who receive treatment as usual.

This study demonstrates the difficulty and intensity in the recruitment of veterans in intervention studies for mental health reasons. Given that untreated mental illness can lead to many negative consequences and the stigmas associated with mental health use, veterans' engagement and retention in treatment are factors that require further research. The findings here suggest that the VA, DoD, universities and communities should develop projects that allow the use ofresources and develop intervention of programs that enhance treatment usage among combat veterans.

As a more general point, the study team feels there is a broader reason to continue this type of intervention study. An intervention such as the one described for this project could be of tremendous value to the many veterans now and in the future who are troubled by their war experiences yet are reluctant to commit to counseling As a more general point, the study team feels there is a broader reason to continue this type of intervention study. An intervention such as the one described for this project could be of tremendous value to the many veterans now and in the future who are troubled by their war experiences yet are reluctant to commit to counseling.

The results revealed several challenges recruiting combat veterans for participating in an intervention study. There have been lessons learned about the recruitment of combat veterans for intervention studies. Most of the veterans were recruited from various stand down events, suggesting stand downs may be one effective means of reaching veterans. Second, researchers need to develop relationships with people in the community who work with veterans prior to starting an intervention study. Third, community and university collaborations can be problematic when working with agencies not familiar with this type ofresearch funding and/or research population, suggesting the need for greater education. Fourth, researchers need to actively seek out Guard Unit Commanders within their respective states to ensure their understanding of the project and their support recruiting for any type of research projects that could involve Guard participants. Finally, there exist logistical and physical barriers that may hinder access to attendance with intervention research; such as: scheduling, lack of childcare and/or transportation. Future interventions should be developed that address these barriers.

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Introduction

This study tested a motivational enhancement (ME) intervention that addresses barriers to engaging in mental health treatment for recently returned veterans of Operation Iraqi Freedom and Operation Enduring Freedom. The long term goal was to increase veterans' participation in mental health treatment by using a Stages of Change (Prochaska, DiClemente& Norcross, 1993) model to reduce perceived stigma and barriers to mental health treatment. The central hypothesis is that veterans who receive motivational enhancement will demonstrate greater readiness for change and better treatment attendance than those in treatment without motivational intervention. The proposed ME treatment intervention is a promising strategy to target negative beliefs and attitudes about receiving mental health treatment. The use of Peer Support Specialist was also an important contribution to document for treatment engagement. Once tested with veterans not enrolled in formal treatment, the manualized protocol developed for the present study could be adapted for use with veterans in treatment and by other community agencies who come into contact with veterans.

An earmark was granted to the as then titled Detroit-Wayne County Community Mental Health Agency. The project was for a two-year period with a budget of $524, 000. Then project PI was informed by the Department of Defense (DoD) that the project was a research project, rather than a service grant. As a result Wayne State University School of Social Work was contracted to write a proposal for the use of the funding. After many meetings, telephone conferences and resubmissions, a proposal was agreed upon between Wayne County and the DoD. The project kickoff was September 2011. It was entitled: Using Motivational Enhancement among OIF/OEF Veterans Returning to the Community. This research project represents the Detroit Wayne County Community Mental Health Authority's (DWMHA) approach to addressing the needs of returning veterans who experienced mental and emotional challenges in transitioning back to civilian life, as well as facing barriers to successful treatment engagement. The study was conducted with Wayne State University (WSU) and Francis Marion University researchers and treatment staff of Southwest Counseling Solutions (SCS), an experienced mental health provider in Detroit, Michigan located in Wayne County.

Background

Over 1.8 million United States military service members have served in Afghanistan, Iraq, or surrounding territories, with approximately 37% having deployed at least twice (Litz & Schlenger, 2009). Of those, over 15% report significant symptoms of posttraumatic stress disorder (PTSD), depression, generalized anxiety, or substance use problems (Erbes, Curry &Leskela, 2009). Furthermore, 13% of the veterans who sought services from the Veteran's Administration (VA) between 2001 and 2005 were diagnosed with PTSD (Seal, Bertenthal, Miner, Sen, &Marmar, 2007). An extensive amount of research conducted on combat and non-combat war veterans speaks to their vulnerability to acute, chronic or delayed stress reactions after a war (Bray, Fairbanks & Marsden, 1999; Figley, 1986, 1993; Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, & Weiss, et al. 1990; Laufer, Yager, Frey-Wouters, & Donnellan; Stretch, 1985). In addition, it has been documented that after completing their service, many experience adjustment problems, (Jinnett, 1997; Litz&Schlenger, 2009; Thomas, 2001) including major depression, substance abuse, functional impairment in social and employment settings and the increased use of health-care services (Hoge, Auchterlonie& Milliken, 2006; Litz & Schlenger, 2009). Furthermore, due to the many unintended consequences of veterans' war experiences, a significant number of veterans experience high levels of "serious mental illness, homelessness, isolation and loneliness, violence and belligerence, and involvement with the criminal justice system in terms of arrest, conviction and incarceration" (Jinnett, 1997, p. 4). Combat veterans may be particularly susceptible to situational and long-term mental and physical health problems. PSTD is one of the most severe reactions to combat exposure and has been identified as a key contributor to these health problems, including elevated levels of alcohol and drug use (Bray et. al., 1999; Shipherd, Stafford & Tanner, 2005). The VA reports that the diagnosis of mental disorders among the number of Iraq (Operation Iraqi Freedom or OIF) and Afghanistan (Operation Enduring Freedom or OEF) is substantial (Veterans Health Administration, 2008). While the VA has dramatically increased the size of its mental-health staff and programming (Rosenheck& Fontana, 2007) there is still a considerable need for additional services.

Historically, veterans who have difficulty adjusting after their war experience do not seek mental health treatment. The same holds for current returning veterans, despite efforts on the part of the military and the VA

to enhance access to mental health services (Vogt, 2011). Hoge, Castro, Messer, McGurk, Cotting, &Koffman's (2004) study of 3,671 returning OIF/OEF veterans found that those veterans who had been diagnosed with a mental disorder were two times more likely than those not diagnosed to report concerns about possible stigmatization and other barriers to seeking mental health care. Furthermore, of those that reported mental health disorders, only 23 to 40 percent followed through with treatment referrals. Actually, the barriers to help seeking are not unique to the Armed Forces and are most often associated with society's reactions to people with mental illness and individuals' internalization of these perceptions (Corrigan, 2004; Corrigan & Rusch, 2002). That is, people in general do not seek needed mental health services because they worry about what others think, as well as their own perceptions that people with mental health problems are responsible for their own disorders. These public and self-stigmas may be more prevalent among military personnel and veterans as they often fear negative career consequences if they seek mental health services (Gorman, Blow, Ames, & Reed, 2011; Vogt, 2011). This belief is based on the fact that, within the armed forces commanders have access to mental health records for those in their command. In addition, they can be deemed unfit to serve and removed from duty and/or discharged. Vogt (2011) also explains that veterans are concerned that potential federal and state employers may also have access to VA mental health records. Military personnel and veterans are also plagued with self stigmas that discourage them from seeking mental health services. That is, the military places a high value on emotional strength and the ability to handle one's own problems, thus making military personnel and veterans more susceptible than civilians to negative beliefs about mental illness and mental health treatment (Vogt, 2011). Also, the lower sense of unit support for treatment and the negative beliefs about the usefulness of psychotherapy further exacerbates the avoidance of mental health services (Murphy, Thompson, Murray, Rainey & Uddo, 2009; Olden, Cukor, Rizzo, Rothbaum & Difede, 2010). Individual determinants of mental health can be barriers to help seeking also. Predisposing characteristics such as age, gender, race and income can affect general attitudes towards mental health service use (Druss & Rosenheck, 1997). In fact, it is reported that males, older veterans, veterans with service connected disabilities and having severe health problems are predictors of more service use in general, and that may be true for mental health services as well (Vogt, 2011). Finally logistical and physical barriers may hinder access to care (Druss & Rosenheck, 1997;

Gorman et al, 2011; Kelly, Merrill, Shumway, Alvidrez & Boccellari, 2010; Olden et al; 2010; Vogt, 2011); these barriers include distance from VA health facilities and service availability, waiting times and paper work, and difficulty navigating the VA health system. These findings demonstrate that minimizing stigmas and barriers should be a critical priority for this population.

There are unique circumstances that need to be considered in mental health treatment of OIF/OEF veterans. These veterans are newly experiencing the psychological effects of their war experience and thus may have different treatment needs than those seen in veterans from earlier wars. These factors may lead to differences in engagement with treatment and different presenting problems and priorities. Researchers have found that OIF/OEF veterans are less likely to attend therapy for extended periods of time and are more likely to discontinue treatment once started (Erbes et al., 2009). Murphy and colleagues (2002) suggest that this resistance may not be due to inadequate interventions, but rather to poor treatment engagement, resulting, in part, from ambivalence about or lack of awareness about the need to change. That is, these combat veterans may not see problem behaviors and coping styles as psychological symptoms, but, rather as highly functional coping strategies needed for living in a world filled with mistrust (Murphy, Rosen, Cameron, & Thompson, 2002). According to Erbes et al., (2009) veterans recently separated from the armed forces continue to have ties with active duty members, reinforcing their skepticism about seeking treatment and resulting in low rates of service use, even among those with significant mental health symptoms. Creative interventions are needed to address the needs of these veterans. This study used an evidence-based intervention to engage veterans with mental health problems who were not participating in formal mental health treatment.

Transtheoretical stages of change Model (TTM) (Prochaska, DiClemente& Norcross, 1993) is a useful theory in understanding and engaging veterans in treatment. The theory focuses on how people change with psychotherapy, and is based on the assumption that the beliefs about the need to change, not personality traits of denial or negative attitudes, underlie the behavioral change process and response to treatment. The theory describes five stages associated with different beliefs about the need to change and the actions towards change. The stages include: pre-contemplation, lack of awareness that a problem exists; contemplation, ambivalence about the need to change; preparation, taking initial steps towards change; action, engagement in efforts to

change; and maintenance, maintaining change. Moving individuals through each stage requires specific motivational techniques and intervention that will enhance their readiness to change. Murphy and Rosen (2006) have adapted the model to address PTSD among combat veterans, specifically their ambivalence about change, mistrust and the misperceptions of problematic behaviors and coping styles. Recent research has demonstrated the use of this model among veterans with PTSD (Murphy, Thompson, Murray, Rainey, & Uddo, 2009). This important research helped to develop motivational-enhancement groups which have the potential to produce effective treatment for PTSD, as well as other mental-health disorders. The clinical techniques of the motivational enhancement group are a modified version of motivational interviewing (MI), an evidenced-based intervention shown to be effective in modifying beliefs about the need to change and promoting change for a variety of behaviors (Bien, Miller, & Tonigan, 1993; Burke, Arkowitz, & Menchola, 2003; Miller, Benefield, & Tonigan, 1993; Murphy, Thompson, Murray, Rainey & Uddo, 2009). Reflective listening plays a major role in this clinical intervention. The groups are impartial and not confrontational. Methods employed include: norm comparison, decision balance, development of discrepancy between values and behavior, and ambivalence amplification (Miller & Rollnick, 2002). This type of intervention has been used successfully in a variety of clinical approaches such as: reducing HIV risk behaviors (Carey, Maisto, Kalichman, Forsyth, Wright, & Johnson, 1997) and alcohol use by college students (Borsani& Carey, 2000), working with problem drinkers (Miller, Benefield, &Tonigan, 1993), treating alcoholics with anger issues (Project Match Research Group, 1998) and improving outcomes in the treatment of non-PTSD anxiety disorders (Tolin, Maltby, Diefenbach, &Worhunsky, 2004; Westra & Dozois, 2006; Arkowitz, Westra, Miller, & Rollnick, 2008). However, further studies and evaluation are needed to examine readiness-to-change models among the OIF/OEF population, particularly among veterans who are skeptical about getting help for mental health problems.

To further enhance the intervention, a Peer Support Specialist was also used to further enhance veterans' readiness to change. The use of Peer Support Specialist in the treatment of combat veterans is not new. Indeed, following the Vietnam War the VA established Vet centers that employed combat veterans from previous wars to assist with the social adjustment of those returning from Viet Nam. The primary method of treatment for these centers included peer counselors that conducted groups called "rap sessions" (Sipprelle, 1992). Vet

centers are still providing veterans with mental-health services and they have become quite sophisticated in their interventions. They often include Peer Support Specialist and rely on the camaraderie and trust returning veterans may have with other combat veterans. Reportedly, the use of peers helps to minimize any alienation or distrust (Church, 2009; Sipprelle, 1992). While peer support has been demonstrated to be effective with veterans, research in this area has been sparse and the technique has not been tested with ME groups.

The current project's aim was to increase veterans' acceptance of mental health treatment, based on the belief that there are two primary obstacles to treatment acceptance: 1) ambivalence about the need to change or lack of awareness of problems, and 2) problematic beliefs and concerns/fears about counseling. The main research objective was to test a Motivational Enhancement intervention that addresses barriers to engaging in mental health treatment among recently returned veterans of Operation Iraqi Freedom and Operation Enduring Freedom who have not yet been involved in formal treatment. A secondary objective was to adapt an existing evidence-based ME protocol that increases veterans' recognition of the need to change, helps them recognize the roadblocks, and stresses the importance of treatment. A third objective was to evaluate the use of multiple methods of outreach to reach veterans and their satisfaction with this innovative approach to treatment engagement. Veterans were recruited and screened for mental health problems to participate in the study, and randomly assigned to a new protocol in which they will receive a Motivational Enhancement intervention. Participants received a minimum of six weekly sessions conducted by trained therapists who explored and resolved ambivalence about seeking treatment for mental health problems and reduced barriers to entering treatment. Control participants received treatment as usual, which included resource information and referrals to appropriate agencies and organizations. The following hypotheses were tested:

H1. Veterans receiving Motivational Enhancement will demonstrate greater readiness to change and perception of relevancy of treatment relevancy compared to the control group.
H2.Veterans receiving Motivational Enhancement will demonstrate higher treatment program attendance (e.g., admission to treatment as well as longer length of stay once admittedinto treatment) compared to the control group.

Due to many logistical and administrative matters, the project faced a number of initial challenges. These included a prolonged process for obtaining the initial protocol approval, a PI change, an agency name and administration change, the securing of IRB approval for all agencies involved and difficulty recruiting OIF/OEF

veterans. As a result, the project milestone chart was revised several times and two No Cost Extensions were requested.

Methods

The main objective was to address barriers to engaging in mental health treatment for recently returned veterans of Operation Iraqi Freedom and Operation Enduring Freedom by testing a ME intervention. The long term goal is to increase veteran's participation in mental health treatment by using the stages-of-change model to reduce perceived stigma and barriers to treatment. The central hypothesis put forth is that veterans who receive motivational enhancement will demonstrate greater readiness for change and higher treatment program attendance than veterans with other treatment. The study consists of three phases:

Phase 1
The finalization and adaptation of the treatment plan and the training of treatment staff and peer support specialist.

Phase 2
The implementation of the ME group study intervention.

Phase 3
Collect data as to the best methods of for recruiting veterans for the study and to evaluate their satisfaction with the intervention program.

Phase 1—The finalization and adaptation of the treatment plan and the training of treatment staff and peer support specialist.

The first task for the co-PI Dr. Murphy was to integrate two new sessions into the core components of the Motivation Enhancement Group Therapist Manual. The general therapeutic approach used in the core components is consistent with MI, in that group leaders respond to patient resistance with empathy, rather than confrontation. The first four sessions involved identification of potential unrecognized problems, psycho education regarding development of a cognitive style that encourages responsibility-taking for adaptive coping, use of decisional-balance and norm-comparison activities to increase problem recognition and motivation to change, and identification of cognitive and emotional roadblocks to recognizing and admitting problems resulting from warzone experiences. The last two sessions addressed beliefs about counseling. An assessment form, Beliefs About Post Deployment Counseling Questionnaire (BAPCQ), is the focus of the client's activity in these final sessions. On this form participants identified beliefs and fears that are potential barriers to

counseling, and counselors helped clients select one or more of these beliefs on which to intervene and change. These include: past negative experiences with counseling, role expectancies (role of patient, role of therapist; e.g., how directive), process and outcome expectancies (self-efficacy about ability to do what's necessary in counseling, as well as confidence that it will work); credibility of the rationale for therapy; concerns about effect of counseling being noted in their military record or ability to re-deploy; numerous fears and stigma (e.g., going crazy, being reported, crying, being humiliated, embarrassed, feeling or being seen as weak); other treatment expectancies; and realistic barriers (childcare, travel, and finances). The final session involved cognitive and behavioral interventions that addressed these problematic beliefs and concerns.

Once the content was drafted, we asked local clinicians and experts for feedback on the adapted motivational intervention protocol. In addition, a group of national experts on motivational interviewing were asked to review manual materials and processes related to the intervention. The results of feedback from clinicians and experts assisted in the further revisions of the manual and finalization of materials. The aim was to do the revisions based on feedback that would make the intervention practical and comprehensible to veterans.

We conducted a pilot group to inform any changes and/or enhance user friendliness of the project manuals. Unfortunately the IRB application was submitted without sufficient time for approval before the expiration date of February 4, 2014. As a result, the project was out of compliance from February 4, 2014 through February 20, 2014. Consequently, any data collected during this time period could not be used and can never be reported or published as research data. The data collected was related to the pilot group which began February 6, 2014. Six veterans in the pilot study were consented and given questionnaires to complete. Once the continuation of the IRB protocol was granted, veterans were notified of the lapse and were re-consented.

Continuation for the protocol was APPROVED following Full Board review by the Wayne State University Institutional Review Board (B3) for the period of 02/20/2014 through 02/19/2015. The Co- PI, Shirley Thomas, completed an Unexpected Problem (UP) Report Form dated February 19, 2014. The unexpected problem event reviewer examined the UP report and forwarded it to the full IRB for consideration. The IRB conducted an audit of the project and a full board review was conducted. On May 15, 2014 the B3 IRB

met and discussed the audit results. The PI agreed not to use the data collected on the 6 participants and the PI's corrective action plan. The B3 IRB also discussed the auditor's recommendations that the corrective action plan be made consistent with filing the next continuation request and that reminders be in place to ensure timely submission of the continuation. The auditor also recommended that the study be re-audited in 6-months to ensure correct usage of IRB-approved data collection tools and posting of the annual continuation dates. The B3 IRB voted to accept the auditor's recommendations. After a second audit October 15, 2014, the project was found to be in compliance. Approval from the U.S. Army Medical Research Acquisition Activity and the USAMRMC, Office of Research Protections was granted. The final manual was approved in September 2014.

A second task during this phase of the intervention involved Dr. Murphy conducting a two-day, on-site training on the adapted motivational enhancement strategy with the SCS treatment staff, and principal investigators, including the Peer Support Specialist. The group felt it best that the training of the therapists and peer support specialist just before the project began. He trained project staff in the use of the manual, and provided feedback to improve presentations. The manual was reviewed, and areas that were unclear to the therapists or that required higher levels of skill to be implemented were discussed and role-play was added to increase effectiveness of interventions. Training continued via skype and/or telephone conference until after the pilot project was completed.

Dr. Murphy supervised and coached therapists during the pilot testing and implementation, focusing on improving therapists' delivery skills, and on helping therapists respond to consumer ambivalence about the need to change and task noncompliance. He also helped them problem-solve practical issues arising from the intervention. Dr. Murphy, along with the SCS supervisor, also monitored the fidelity of the intervention. The supervision philosophy was based on Miller and colleagues' Motivational Interviewing principles, cognitive-behavioral learning principles, and behavioral coaching. To accomplish this, group sessions were recorded, placed on an encrypted flash and mailed to Dr. Murphy.

The Peer Support Specialist (PSS) was trained along with the therapists to maximize motivation and reduce barriers to engaging in treatment. PSS attempted to make contact at least three times with each participant; including those in the control group. For example, early in the intervention they assisted

participants to understand the problem and reinforced the use of decision-making tools to draw accurate conclusions about what problems they needed help with. Later in the intervention the Peer Support Specialist can helped identify misperceptions of counseling that hindered treatment engagement and supported their willingness to consider the need for help. Another important goal for the Peer Support Specialists was to maintain contact with participants for data collection. Peer Support Specialist served an important role in mental health recovery and this study expands our knowledge on how to support veterans' decisions to seek assistance for their mental health problems.

Finally, Dr. Murphy conducted a seminar for project staff and any interested community healthcare providers about veterans' post-deployment issues, including posttraumatic stress disorder and other stress symptoms. The seminar focused on symptoms of trauma-based stress, the nature of combat, typical treatment approaches, and the application of motivational interviewing/transtheoretical model principles to encourage veterans to engage in mental health treatment. The 4-hour seminar was attended by the project staff, the Wayne County Community Mental Health Agency, and local community mental health care providers interested in dealing with post-deployment stress and treatment engagement. The seminar served as a kick-off for the project and participants provided a list of potential referral sources for recruitment.

Phase 2—The implementation of the ME group study intervention.

The implementation of the ME groups proved difficult due to the low numbers of OIF/OEF veterans participating in community agencies and events. The inclusion/exclusion for this study is below:

> Returning Operation Iraqi Freedom and Operation Enduring Freedom will be eligible to participate in the study. Veterans will be excluded if their scores indicate active psychoses; they have a diagnosis of traumatic brain injury or are receiving formal mental health treatment. Veterans that report symptoms of PTSD, mood disorders, anxiety, substance abuse, eating disorders, somatoform or depression will be included in the study.

Difficulty in recruiting OIF/OEF veterans seemed to be related to two factors: Veterans had to live in Wayne County and they could not have been already in counseling. To address this, the project team requested permission from DWCMA to lift this inclusion criterion. Primarily because efforts to recruit in Wayne County did not produce the desired number of subjects; also, VA social workers informed us that, for the Detroit

Veterans Hospital, the majority of the veterans report Macomb, Oakland and Genesee counties as their places of residence. Second, to further aid with recruiting, the team decided to change the eligibility criteria for the study. Originally, the emphasis was on veterans that had not received any mental-health treatment. The team discussed opening it up to those that may be in treatment or have attended treatment briefly in the past. This change was supported by the literature, in that many combat veterans do not enter treatment and if they do go to treatment, they do not stay long. According to Dr. Ron Murphy, a co-PI of the project and an expert on the current method of intervention, all of the groups he has conducted using the earlier version of the intervention was with veterans already in therapy. That is, the groups were generally conducted among veterans early in treatment. The primary intent of the intervention has always been to enhance veterans' treatment follow-through or increase their chances of returning to treatment. In real world applications of the intervention, there are few situations in which veterans not in treatment could be gathered and given the intervention. So changing the eligibility requirement of not being in treatment does not impact the intervention's generalizability or applicability.

Throughout the course of the study we have looked to recruit from any community organization that may come in to contact with OIF/OEF Veterans. In order to help spread the word to potential participants we continually reached out and provided information and fliers to both personal and agency contacts. Several of the organizations and names were gathered from attending stand down events in the area, networking at veteran events around the city and from the kick-off seminar. We made similar contacts with all the community colleges in and around Wayne County that have veterans divisions. Other organizations have been located through internet searches to find nearby veteran centers and VFW posts which may allow us to put up signs and help with recruitment. In addition we have met and discussed the project with the staff at the WSU veterans' office and the faculty at the WSU School of Social Work to develop additional avenues for recruitment of OIF/OEF veterans and to find the best practices for recruiting challenging research participants.

Fliers were posted in and near local businesses, such as book stores, bars and restaurants. A media spot was placed on CBS-97.1. It included a clickable banner for those listening online. To find new ways to reach OIF/OEF veterans and other organizations, we created a Facebook page. Two veterans were hired to help go out

to the different organizations and spend some time with them to encourage other veterans to participate. One of these veterans got full time employment and was unable to continue with the project. The remaining part-time recruiter worked for three months. He was able to meet with people at Selfridge Air National Guard Base and generate relationships with the people at Veterans Haven. His contacts are also in the appendix. An original recruitment strategy was to coordinate with the National Guard Unit in Lansing, Michigan, which processes returning OIF/OEF veterans. However, this did not work out because they deemed this "was a research project" and therefore we were only allowed to mail them flyers to be posted at the different Guard sites.

Each week a veteran's court is held at the Redford County Court. Through networking we were invited to attend meetings prior to the court sessions and talk about the project in an effort to recruit participants. The research assistant continued to attend every month to maintain a presence and to promote the project, hoping that some of the veterans would agree to participate. There were not many OIF/OEF veterans in attendance and few, if any of those, agreed to participate in the project. When WCMHA applied for the grant money to help with returning veterans, it was expected that the agency would see an increase in OIF/OEF coming in for services. This was not the case. There was an increase, but not among OIF/OEF veterans. At any rate, the community agencies that operate under the umbrella of WCMHA reported the list of veterans requesting service quarterly. Any one identifying as a veteran was mailed information about the project. However, no OIF/OEF veterans responded.

Potential participants were asked to join a study of a group-counseling technique for helping veterans decide if they want to engage in counseling for post-deployment stress problems. They were informed that participants may be assigned to the intervention group or a control group in which they would not receive the intervention. Potential participants were told the following:

> The group intervention is not treatment for stress problems, but a set of techniques for deciding two things: one, if they need counseling for post-deployment stress problems, and two, if their beliefs and concerns about counseling should stop them from receiving counseling when they may benefit from it. Participants in the intervention get an assessment of their perceptions of the need for counseling and their beliefs about counseling. These beliefs are discussed and explored with counselors and fellow

veterans. Then, participants learn various decision-making techniques that help them decide if they need counseling, and also review their beliefs about counseling. Group leaders then guide participants in exploring any misperceptions about counseling for post-deployment problems and also address fears and concerns about the process and outcome of counseling. The ultimate goal is for veterans to decide for themselves if they want to engage in post-deployment stress treatment.

Veterans who expressed an interest in person were provided with an information sheet describing the study, risks and benefits and asked to complete a screening packet of information. Veterans who learn about the study through other methods were asked to call the research project number and they were verbally consented for the screen. The research assistant administered the screening instruments over the telephone, taking care to ensure confidentiality of responses. Individuals had the option of being sent a packet through the U.S. mail, including study description, consents, and screening instruments. The packet contained information to screen veterans for eligibility to participate. Screening tools include PRIME-MD (Primary Care Evaluation of Mental Disorders Patient Health Questionnaire) (Spitzer, Kroenke, & Williams, 1999). This is a 3-page tool that can be self-administered or read and assesses 8 disorders (divided into threshold disorders, such as major depressive disorder, panic disorder and sub threshold disorders such as alcohol abuse or dependence). The PHQ takes about five minutes to complete and has diagnostic validity with established thresholds for each of the disorders. A brief questionnaire on current involvement in mental health treatment was also used. A small incentive ($10 gift card) was provided to each veteran who completed the eligibility screening questions. Veterans that report symptoms of PTSD, mood disorders, anxiety, substance abuse, eating disorders, somatoform or depression were included.

Overall, forty-eight veterans were contacted for screenings, either via the telephone or through the mail; twenty-six screenings were received. Every veteran that returned a pre-screen received a $25 gift card. Veterans received $50 to complete the post-test and the 3 month follow-up. Veterans that were assigned to the treatment group received $35 for attending each weekly 2- hour session. Each veteran that returned a screen was contacted at least three times by phone, email or text by the research assistant and invited to join the actual group The Dr. Thomas, co-PI also made contact to see if participation would improve. Once a veteran

completed the paper work and was scheduled to meet in group, they received additional support calls from the Peer Support Specialist.

Results

Recruitment Sample.

A total of 48 veterans were contacted and asked to fill out a screening, and a total of twenty six screenings were returned. The recruitment strategies did not produce the desired outcome of 100 veterans—fifty for the control and fifty for the treatment group. Of the screenings received, ten veterans identified their branch of service as Army; seven reported that they were Marines; two were Air Force and one each reported service in the Navy, National Guard, Reserve and IMA; seven reported "other". Among those that returned the screens, 14 out of 26 reported that they were currently receiving mental health services. When asked how they heard about the ME groups 11 respondents reported "other". The results are listed in Table 1. The “other” is probably from the stand downs—since this is how the project staff met most of the screened veterans. Twenty-three percent reported that they heard about the project through the VA and four heard about the groups from the University.

HOW DID YOU FIND OUT ABOUT THE PROJECT (Table 1)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	SPOUSE/FRIEND/FAMIY	2	7.7	7.7	7.7
	SOCIAL MEDIA/FACEBOOK/EMAIL/TWITTER	1	3.8	3.8	11.5
	FRIEND/FAMILY MEMBER	2	7.7	7.7	19.2
	COLLEGE/UNIVERSITY	4	15.4	15.4	34.6
	VETERANS AFFAIRS	6	23.1	23.1	57.7
	OTHER	11	42.3	42.3	100.0
	Total	26	100.0	100.0	

Intervention Study Sample.

We were able to complete one cycle of the intervention component of the study. Table 2 reports the number of participants in the control group (2) and treatment group (5).

Person in treatment or control group (Table 2)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	control	2	28.6	28.6	28.6
	treatment	5	71.4	71.4	100.0
	Total	7	100.0	100.0	

Of the seven participants in the intervention and control group, four were Army, two were Marines and one was in the Air Force. Four of the participants were receiving some type of post deployment mental health services. Of the veterans in study, five veterans reported that their annual household incomes in 2011 was below $60 thousand dollars with two reporting earning over $60 thousand dollars. Three of the veterans reported that they found out about the ME groups through their college/university campus. Two reported that they found out about the group through other means. One each found out about the groups from the VA or Facebook. It should be noted that there were two females who attended the consent meeting to complete the pre-assessment paperwork. One did not return and the other completed the sessions.

Findings.

Respondents reported reasons for seeking and not seeking counseling in an instrument completed at the intervention baseline, following the intervention at 6 Weeks, and at three months following the intervention. One veteran each indicated that he/she they could not seek counseling for the following seven reasons: fear of being pressured to do things I don't want to do; other people would look at me negatively if they knew I was in counseling; fear of rejection; fear of rejection; fear of feeling overwhelmed; family responsibility; non-military therapist won't be able to understand me or my experiences; and shameful to tell other people your problems. Fear of rejection was the only response that disappeared at the 6 week post intervention assessment; the others remained. Twelve responses were reported following the intervention that were not present at baseline: feel ashamed of being in counseling; fear of change; fear of embarrassment; fear of emotions coming up; fear of finding out I am crazy; fear that others will think I am crazy; fear of being judged; and admitting a problem equals weakness. Veterans reported the same reasons for not attending treatment at the three month follow-up with the addition of fear of feeling weak; although only two participants completed the three month follow-up questionnaire. Two veterans each checked that the fear of being seen as damaged and can't afford transportation costs (gas, etc) as the reasons they could not attend counseling. Three veterans reported that their jobs and don't want to think about the past as reasons for not attending therapy. The most reasons given by the veterans for not wanting to attend counseling was that they did not want to have feelings of failure.

Veterans were asked to respond to the following questions pre/post and at the three month follow-up concerning their beliefs about counseling.

What has been your experience in seeking counseling for post-deployment problems?
What are your expectations about what happens in counseling?
What are your beliefs about how counseling works?
What is your role in counseling?
What is the counselor's role?
What concerns do you have about what might happen in counseling for post- deployment problems?

Veterans reported mixed perceptions regarding post-deployment counseling experiences. Some felt the VA system was helpful other did not; and concerns were noted especially the Detroit VA system. One veteran did report that he has not had any "luck" getting help, and he further stated that people often say he looks "ok" and telling him "you know that you can't get a job if you get help." One veteran felt services were more focused on Vietnam era veterans and male veterans. Veterans during the post intervention (at 6 weeks) phase

also expressed mixed feelings about counseling. One respondent reported the perception that counseling can help, while another reported that in Michigan although one veteran reported they had trouble finding treatment that is specific to OIF/OEF veterans. Similar findings were reported in the responses from the two veterans in the three month follow-up period. In contrast, a female veteran stated it was easier to receive services specific for female veterans in another state.

Regarding expectations of counseling, participants reported that they expected to talk about feelings and behaviors and they hoped to learn how to manage PTSD symptoms when immediate treatment was not available. At the six week post intervention sessions most of the veterans continued to state that they expected to find help and to talk, listen and find healthy coping mechanisms. At the three month follow-up only two veterans responded. Both reported that counseling might be helpful and that they would be able to expose concerns in a confidential way and get advice on solving issues.

Participants reported that their role in counseling was to be truthful, straight forward and not to minimize the trauma they experienced. One veteran stated "My rule is to let the counselor do their job" and another stated their role as "to express my concerns or experiences with the counselor, so I can get advice on what happen and how to better prepare myself for other occurrences". Veterans said similar things post intervention as well; to be open, truthful, to listen, and to improve. One veteran stated that veterans must put the work in to see results. The two veterans in the three-month follow-up stated that their role in counseling was to learn how to "fix your problems", as well as expressing issues and feelings in confidence and attempt to follow a treatment plan.

Regarding the counselor's role, veterans expressed that counselors should be empathetic, listen, understanding, just, beneficial and "non-malice". They also reported that their role was "To help you in the areas in which you need it and establish goals…to listen to participant and not tell them what they should do or feel but help provide guidance to healthy coping mechanisms". After the six week sessions veterans also reported similar expectations from the counselor one stated "to help find healthy and successful ways to deal with said problems", At the three month follow-up the theme was the same "to assist patient in finding healthy ways to problem solve".

Six of the seven were concerned that in counseling they might stir up buried memories, dreams and/or trauma they may not be able to handle or that they could not deal with. However one participant did add that "Dreams may resurface but yet treatment reestablishes a base of comfortability that all is well". One veteran stated that there was some concern that "there is a lack of understanding from the counselor's point of view, as I believe combat related behavior problems are different than civilian ones". After the intervention veterans reported that they were concerned about sharing their true feelings, that the counseling does not work and/or that counselors are able to connect relate". Only one concern was reported at the three month follow-up, that "The patient doesn't feel comfortable with counselor or has to deal with getting passed around from provider to provider, due to medical insurance or counselor leaving".

In sum, it appears that the seven veterans from this sample have fears about attending counseling and concerns about how they will be perceived by others for attending therapy. It was important to the veterans that counselors understood their past military experiences yet they feel hopeful that therapy could work. While this sample is very small their responses appear to be in-line with responses given by other combat veterans. In addition it should be noted that there could have been different responses if the participants were not in therapy currently or in the past.

Conclusion

The main research objective was to test a Motivational Enhancement intervention that addressed barriers to engaging in mental health treatment among recently returned veterans of Operation Iraqi Freedom and Operation Enduring Freedom veterans. The aim of the intervention was to increase veterans' acceptance of mental health treatment. The rationale for the intervention is based on the belief that there are two primary obstacles to treatment acceptance: 1) ambivalence about the need to change or lack of awareness of problems, and 2) problematic beliefs and concerns/fears about counseling.

The results revealed several challenges in recruiting combat veterans for participating in an intervention study. Of the 23 veterans who agreed to participate in the study, only seven followed through with the study protocol. There have been a number of lessons learned thus far about the recruitment of combat veterans for intervention studies. First, most of the veterans that we were able to recruit came from the various stand downs

the team attended. This suggests that stand downs may be an effective means of reaching veterans, but that future studies should expand efforts to recruit participants who are willing and interested in participating in intervention studies designed to address their specific needs. Second, researchers need to develop a resource pool and relationships with people in the community who work with veterans prior to starting an intervention study. Third, community and university collaborations can be problematic when working with agencies not familiar with this type of research funding and/or research population, suggesting the need for greater education, community-level participation, and dialog prior to study commencement. Fourth, researchers need to actively seek out Guard Unit Commanders within their respective states to ensure their understanding of the project and their support for the recruiting for any type of research projects that could involve Guard participants. Finally, there exist logistical and physical barriers that may facilitate or hinder access to attendance as well as follow through with intervention research; such as: scheduling, lack of childcare and/or transportation. Future interventions should be developed that address these barriers through enhanced resources, programming, and scheduling.

This study demonstrates the difficulty and intensity in the recruitment of veterans in intervention studies for mental health reasons. Given that untreated mental illness can lead to many negative consequences and the stigmas associated with mental health use, veterans' engagement and retention in treatment are factors that require further research. The findings here suggest that the VA, DoD, universities and communities should develop projects that allow the use of resources and develop intervention of programs that enhance treatment usage among combat veterans.

As a more general point, the study team feels there is a broader reason to continue this type of intervention study. An intervention such as the one described for this project could be of tremendous value to the many veterans now and in the future who are troubled by their war experiences yet are reluctant to commit to counseling.

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